| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING 00<br>B. WING | 06/07/2011 |

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| F0000 | This visit was for the Investigation of Complaint IN00090935.<br><br>Complaint IN00090935- Substantiated, federal/state deficiencies related to the allegations are cited at F 225, F 226, F 282, and F 385.<br><br>Survey dates: June 6 and 7, 2011<br><br>Facility number: 000577<br>Provider number: 155650<br>AIM number: 100266950<br><br>Survey team:<br>Janelyn Kulik, RN, TC<br>Janet Adams, RN<br>(June 6, 2011)<br><br>Census bed type:<br>SNF/NF: 80<br>Total: 80<br><br>Census payor type:<br>Medicare: 18<br>Medicaid: 55<br>Other: 7<br>Total: 80<br><br>Sample: 9<br><br>These Deficiencies also reflect State | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on June 10, 2011 by Bev Faulkner, RN | | | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on record review and interview, the facility failed to ensure an allegation of abuse was reported promptly to the Administrator and the alleged staff member was removed form resident care | F0225 | F225<br>1. Residenti#H was assessed ffor physical and emotional injury, none notied | 07/07/2011 |

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| | until the completion of the investigation of the allegation of abuse for 1 of 3 residents reviewed for allegations of abuse in a sample of 9. (Resident #H and CNA #1)<br><br>Findings include:<br><br>Review of a reportable incident provided by the Director of Nursing (DoN) and reviewed on 6/7/11 at 11:00 a.m., indicated the date of the incident was 4/16/11.<br>Brief description of the incident:<br>"(Resident #H's name) reported to her nurse that was caring for her on her last shower day which was 4-16-2011 that her CNA (CNA #1's name) was mean and would not give her clothes to her and she jerked her arm. All this was stated to have occurred during her shower. Writer interviewed (Resident #H's name) and she stated that on her last shower day her CNA in which she could not remember her name, but did describe her as the one that wears the jacket around her waist all the time and and (sic) acts funny (humorous) was complaining about lifting her and stated that she was not going to ruin her health lifting and kept going on about it. (Resident #H's name) stated that while transferring to the shower chair she was unsteady and missed the chair and the CNA jerked her by her right arm. She | | As stiatied in tih2567, CNA #1 was suspended upon being notiffed off abuse allegation on 4/18/11, and investigation was conductied CNA #1 was re-educatied on abuse and custiomer service prior tio retiurning tio work ati conclusion off investigation.<br>LPN #1 and LPN #2 were re-educatied on 4/19/11 regarding immediatie reporting off abuse allegations tio tihe Administratior<br><br>2. All abuse allegation reportis since 4/1/11 have been reviewed tio identiffy any otiher potiential deffcienti practices in timely notiffcation, and no ffurtiher issues were identiffed<br><br>3. In-service ffor all stiaff was completied on4/21/11 and 4/22/11 regarding abuse allegations and tihe immediatie reporting off abuse allegations tio tihe Administratior<br><br>The Administratior or designee will auditi employee ffles tio identiffy any stiaff who has noti received in-service on abuse and reporting off abuse, including all employees hired since 1/1/11. All stiaff identiffed will receive an in-service on abuse and abuse reporting by 7/7/11.<br><br>All new employees will receive abuse tiraining during tihe ffrsti day off new employee orientiation and will | |

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| | also stated that the CNA would not give her clothes to her, and she took them out of her hands and the other girl gave them back. (Resident #H's name) stated that her clothes are not labeled and she did not want them to get lost. (Resident #H's name) also stated that there was another resident in the shower room that heard everything; and the CNA also stated that she have (sic) people working here. (Resident #H's name) said that as they came out of the shower room, her and the CNA continue(sic) to argue.<br>Interviews were completed with other staff members that worked that shift and no one gave statement as to hearing or seeing what happened besides one other CNA and she stated that she only heard both sides of the story from (Resident #H's name) and CNA (CNA #1's name), but could not be counted as a witness to the event. This writer interviewed the resident that was in the shower room at the time of this incident, but she could not remember anything that happened in there and stated that she was sorry that she could not help me."<br>Immediate action taken: "Immediately after the shower was over according to (Resident #H's name) she went back to her room. Shortly after that (Resident #H's name) stated that's when she reported the incident to her nurse."<br>Preventive measures taken: "The CNA | | successffully completie a postiesti tio ensure understianding off abuse and abuse reporting.<br><br>The Administratior or designee will review all new employee ffles witihin 72 hours off orientiation class tio ensure tihati abuse tiraining is completied on ffrsti day off new employee orientiation<br><br>The Administratiors cell phone number has been postied in designatied areas available ffor all stiaff All abuse allegations will be reportied tio tihe Administratior The Administratior will review all abuse allegations reportied immediatiely by tihe stiaff and ensure tihati tihe alleged stiaff members are removed ffrom residenti care until tihe completion off tihe investigation off tihe abuse allegation.<br><br>4. The resultis off tihese ffndings will be reviewed in tihe Qualitiy Assurance meeting montihly x3, tihen quartierly x2 tio ensure compliance<br><br>5. Compliance datie July 7, 2011 | |

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| | has been suspended pending investigation at this time."<br><br>A statement written by LPN #1 indicated, "On Saturday April 16, 2011 at about 1700 (5:00 p.m.) (Resident #H's name) reported to me after leaving out (sic) the shower that CNA (CNA #1's name) was being very mean to me. She pulled on my arm and said mean things to me. CNA (CNA #1's name) denied everything that was said and stated 'Umm I got a witness, another lady in there ask her.' That lady was (Resident #J's name) I asked her what happened and did she her (sic) anything she stated 'no, idk (I don't know).' "<br><br>A statement written by LPN #2 indicated she worked the B wing on April 16, 2011. "I was sitting down at the nurse's station charting, I was approached by (Resident #H's name). (Resident #H's name) asked me if I would call her daughter (daughter's name) for her. I replied back sure and called her daughter. After she completed her phone call, (Resident #H's name) stated to me that I was the only person that has been nice to her. She also stated that the CNA staff has been rough and mean to her since she has been here. I informed the nurse responsible for (Resident #H's name) on 4/16/11 of her allegation to me." This statement was signed by LPN #2 and dated 4/19/11. | | | |

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| | A written statement obtained from CNA #1 indicated, "Soon as I came on the floor, (Resident #H's name) stay (sic) on her call light, I answered her call light, I told her, please give me a minute. I just got on the floor, let me get my things together, soon as I left the room she got back on her light. I want to get up, I said ok, let me get my things together, I left the room, she were (sic) back on the light, I want my shower. I said ok, let me get it together, then she said I want to use the bathroom. I said ok, so what I did (sic) I got her up, when on (sic) took her to the shower, I ask (sic) her do you steel (sic) have to use the bathroom, she said yes, put her on the tolet (sic), then I put her in the shower, when we finished the shower, I were (sic) drying her off, that's (sic) when I seen (sic) those scards (sic) on her arms, I ask her, what happen (sic) to your arms, she put her head down and said, I broke both of my arms from the way she look (sic), I believe she didn't want to talk about her scards (sic). I ment (sic) no harm after the shower, I was taking her out of the shower room, she said I want my clothing. I told her no, because they are dirty clothing, and I will not give you those dirty clothing, that's when she said her name is not in her clothing, when me and her came out of the shower room, she yelled out she pulled my arms, she pulled | | | |

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| | by arms. I couldn't believe she said this, I told the nurse, no that a (sic) lie. I would not never (sic) hurt these older people for the world, then I told the nurse I refuse to work with her for the rest of the day because I refuse to loose (sic) my job, over her lying on me, I wrote the paper on her first. (Resident #K's name) was satting (sic) beside me, when I was writing the paper out on her, for acking (sic) out and lying on (sic) me. So the nurse told me to trade people with her, everyone told me no way. It was my first time working with her. Now, I see why the other girls say they don't want to work with her, so I took (Resident #K's name) outside of her room. I told him I need you to help me, when I go in her room I will leave open, so you can here (sic) everything that's going on, because I am afraid I can loose (sic) my job, cause this lady will lie on you (sic). Oh yes I forgot I had help by (Resident #K's name) so that night she had come (sic) down, so I through (sic) the paper away. (Resident #K's name) seen me write the paper and he also seen me through (sic) it away, but I wrote her up first then I said forget it, she is better now."<br><br>Conclusion of events typed by the DoN, indicated "In conclusion writer received statement from alleged CNA (CNA #1's name) in regards to what occurred on the | | | |

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| | day of (Resident #H's name) shower. In the statement (CNA #1's name) states that she did not jerk (Resident #H's name) arm; (Resident #H's name) became unsteady during the transfer from the wheelchair to the shower chair and she states that she held (Resident #H's name) by the hips so that she would not fall and helped her to sit in the chair. She also stated that she asked (Resident #H's name) about the bilateral scars that are located on her shoulders and (Resident #H's name) stated in return that she had broken both of her arms before. She said that she did take the clothes from (Resident #H's name) and she explained to (Resident #H's name) that the clothes were dirty that was the only reason why she was taking them, but (Resident #H's name) did not want her to and the nurse told her to just give them back if that's what she wanted. (CNA #1's name) stated that she was thinking more on the side on (sic) contaminating the clean clothes that (Resident #H's name) had just put on after her shower. (CNA #1's name) also stated that she told (Resident #H's name) that her daughter worked here as well and she never do (sic) anything to jeopardize her job or any resident. She stated that she meant nothing bad by telling (Resident #H's name) that.<br>There was not (sic) abuse found to be true. Three other alert and oriented | | | |

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| | residents were interviewed on the same hall and none of them voiced any complaints about the care that they have received. The CNA (CNA #1's name) was informed that she would no longer take care of the (sic) (Resident #H's name). (CNA #1's name) received one on one coaching regarding how residents may perceive things. An in-service was provided to all of the staff on abuse and customer service."<br><br>The cover letter and fax verification page indicated the information had been faxed to Indiana State Department of Health on 4/18/11.<br><br>The closed record of Resident #H was reviewed on 6/7/11 at 11:15 a.m. Her diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, bipolar, and chronic obstructive pulmonary disease.<br><br>A 14 day Minimum Data Set Assessment, dated 4/21/11, indicated the resident was understood and could understand. She scored a 15 on the Brief Interview of Mental Status which indicated she was cognitively intact.<br><br>Interview with the DoN on 6/7/11 at 11:25 a.m., indicated LPN #1 was the nurse who told CNA #1 to give Resident #H her | | | |

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| | clothes back but she was not in the shower room where the incident happened.<br><br>Interview with the DoN on 6/7/11 at 12:45 p.m., indicated LPN #1 and LPN #2 both were aware of the allegations on the day of the incident. The DoN further indicated she was not made aware of the allegation until she returned to the facility on 4/18/11. She also verified that CNA #1 was not sent home on 4/16/11, the day the allegation was made, but was suspended pending the investigation on 4/18/11. She then indicated that LPN #1 and LPN #2 had not contacted her when the allegation was made because they did not know that was what they were to do in the event of an allegation of abuse.<br><br>Interview with the DoN on 6/7/11 at 2:30 p.m., indicated she immediately informs the Administrator when she receives an allegation of abuse.<br><br>The federal tag relates to Complaint IN00090935.<br><br>3.1-13(g)(1)<br>3.1-28(d) | | | |

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| F0226 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to ensure the facility staff followed its abuse policy regarding reporting all allegations of abuse immediately to the Administrator or the Director of Nursing (DoN) and removing staff member who have been accused of allegations of abuse for the facility until the completion of the investigation for 1 of 3 residents reviewed for allegations of abuse in a sample of 9. (Resident #H and CNA #1)<br><br>Findings include:<br><br>The Abuse, Neglect, and Misappropriation of Resident Property was provided by the Administrator on 6/6/11 at 9:45 a.m. The policy indicated, "The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with state law through established procedures."<br><br>"If resident sustains injury by an employee or employee is a suspected perpetrator: I. Remove the employee immediately. ii. | F0226 | F226<br><br>1. Residenti#H was assessed ffor physical and emotional injury, none notied<br><br>As stiatied in tihe2567, CNA #1 was suspended upon being notiffed off abuse allegation on 4/18/11, and investigation was conductied CNA #1 was re-educatied on abuse and custiomer service prior tio retiurning tio work ati conclusion off investigation.<br>LPN #1 and LPN #2 were re-educatied on 4/19/11 regarding immediatie reporting off abuse allegations tio tihe Administratior<br><br>2. All abuse allegation reportis since 4/1/11 have been reviewed tio identiffy any otiher potiential deffcienti practices in timely notiffcation, and no ffurtiher issues were identiffed<br><br>3. In-service ffor all stiaff was completied on4/21/11 and 4/22/11 regarding abuse allegations and tihe immediatie reporting off abuse allegations tio tihe Administratior<br><br>The Administratior or designee will auditi employee ffles tio identiffy any stiaff who has noti received in-service on abuse and reporting off abuse, including all employees hired since | 07/07/2011 |

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| | Staff is to notify immediate supervisor and he or she must conduct interview with employee and resident. iii. Employee must be sent home (suspended) immediately pending outcome of final investigation. iv. Administrator must be notified immediately of situation, and he/she must conduct an investigation immediately."<br><br>Review of a reportable incident provided by the Director of Nursing (DoN) and reviewed on 6/7/11 at 11:00 a.m., indicated the date of the incident was 4/16/11.<br>Brief description of the incident:<br>"(Resident #H's name) reported to her nurse that was caring for her on her last shower day which was 4-16-2011 that her CNA (CNA #1's name) was mean and would not give her clothes to her and she jerked her arm. All this was stated to have occurred during her shower. Writer interviewed (Resident #H's name) and she stated that on her last shower day her CNA in which she could not remember her name, but did describe her as the one that wears the jacket around her waist all the time and and (sic) acts funny (humorous) was complaining about lifting her and stated that she was not going to ruin her health lifting and kept going on about it. (Resident #H's name) stated that while transferring to the shower chair she | | 1/1/11. All stiaff identiffed will receive an in-service on abuse and abuse reporting by 7/7/11.<br><br>All new employees will receive abuse tiraining during tihe ffrsti day off new employee orientiation and will successffully completie a postiesti tio ensure understianding off abuse and abuse reporting.<br><br>The Administratior or designee will review all new employee ffles witihin 72 hours off orientiation class tio ensure tihati abuse tiraining is completied on ffrsti day off new employee orientiation<br><br>The Administratiors cell phone number has been postied in designatied areas available ffor all stiaff All abuse allegations will be reportied tio tihe Administratior. The Administratior will review all abuse allegations reportied immediatiely by tihe stiaff and ensure tihati tihe alleged stiaff members are removed ffrom residenti care until tihe completion off tihe investigation off tihe abuse allegation.<br><br>4. The resultis off tihese ffndings will be reviewed in tihe Qualitiy Assurance meeting montihly x3, tihen quartierly x2 tio ensure compliance<br><br>5. Compliance datie July 7, 2011 | |

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| | 155650 | A. BUILDING 00<br>B. WING | 06/07/2011 |

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| | was unsteady and missed the chair and the CNA jerked her by her right arm. She also stated that the CNA would not give her clothes to her, and she took them out of her hands and the other girl gave them back. (Resident #H's name) stated that her clothes are not labeled and she did not want them to get lost. (Resident #H's name) also stated that there was another resident in the shower room that heard everything; and the CNA also stated that she have (sic) people working here. (Resident #H's name) said that as they came out of the shower room, her and the CNA continue(sic) to argue.<br>Interviews were completed with other staff members that worked that shift and no one gave statement as to hearing or seeing what happened besides one other CNA and she stated that she only heard both sides of the story from (Resident #H's name) and CNA (CNA #1's name), but could not be counted as a witness to the event. This writer interviewed the resident that was in the shower room at the time of this incident, but she could not remember anything that happened in there and stated that she was sorry that she could not help me."<br>Immediate action taken: "Immediately after the shower was over according to (Resident #H's name) she went back to her room. Shortly after that (Resident #H's name) stated that's when she reported | | | |

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| | the incident to her nurse."<br>Preventive measures taken: "The CNA has been suspended pending investigation at this time."<br><br>A statement written by LPN #1 indicated, "On Saturday April 16, 2011 at about 1700 (5:00 p.m.) (Resident #H's name) reported to me after leaving out (sic) the shower that CNA (CNA #1's name) was being very mean to me. She pulled on my arm and said mean things to me. CNA (CNA #1's name) denied everything that was said and stated "Umm I got a witness, another lady in there ask her." That lady was (Resident #J's name) I asked her what happened and did she her (sic) anything she stated 'no, idk (I don't know).' "<br><br>A statement written by LPN #2 indicated she worked the B wing on April 16, 2011. "I was sitting down at the nurse's station charting, I was approached by (Resident #H's name). (Resident #H's name) asked me if I would call her daughter (daughter's name) for her. I replied back sure and called her daughter. After she completed her phone call, (Resident #H's name) stated to me that I was the only person that has been nice to her. She also stated that the CNA staff has been rough and mean to her since she has been here. I informed the nurse responsible for (Resident #H's name) on 4/16/11 of her | | | |

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| | allegation to me." This statement was signed by LPN #2 and dated 4/19/11.<br><br>A written statement obtained from CNA #1 indicated, "Soon as I came on the floor, (Resident #H's name) stay (sic) on her call light, I answered her call light, I told her, please give me a minute. I just got on the floor, let me get my things together, soon as I left the room she got back on her light. I want to get up, I said ok, let me get my things together, I left the room, she were (sic) back on the light, I want my shower. I said ok, let me get it together, then she said I want to use the bathroom. I said ok, so what I did (sic) I got her up, when on (sic) took her to the shower, I ask (sic) her do you steel (sic) have to use the bathroom, she said yes, put her on the tolet (sic), then I put her in the shower, when we finished the shower, I were (sic) drying her off, that's (sic) when I seen (sic) those scards (sic) on her arms, I ask her, what happen (sic) to your arms, she put her head down and said, I broke both of my arms from the way she look (sic), I believe she didn't want to talk about her scards (sic). I ment (sic) no harm after the shower, I was taking her out of the shower room, she said I want my clothing. I told her no, because they are dirty clothing, and I will not give you those dirty clothing, that's when she said her name is not in her clothing, when me | | | |

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| | and her came out of the shower room, she yelled out she pulled my arms, she pulled by arms. I couldn't believe she said this, I told the nurse, no that a (sic) lie. I would not never (sic) hurt these older people for the world, then I told the nurse I refuse to work with her for the rest of the day because I refuse to loose (sic) my job, over her lying on me, I wrote the paper on her first. (Resident #K's name) was satting (sic) beside me, when I was writing the paper out on her, for acking (sic) out and lying on (sic) me. So the nurse told me to trade people with her, everyone told me no way. It was my first time working with her. Now, I see why the other girls say they don't want to work with her, so I took (Resident #K's name) outside of her room. I told him I need you to help me, when I go in her room I will leave open, so you can here (sic) everything that's going on, because I am afraid I can loose (sic) my job, cause this lady will lie on you (sic). Oh yes I forgot I had help by (Resident #K's name) so that night she had come (sic) down, so I through (sic) the paper away. (Resident #K's name) seen me write the paper and he also seen me through (sic) it away, but I wrote her up first then I said forget it, she is better now."<br><br>Conclusion of events typed by the DoN, indicated "In conclusion writer received | | | |

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| | statement from alleged CNA (CNA #1's name) in regards to what occurred on the day of (Resident #H's name) shower. In the statement (CNA #1's name) states that she did not jerk (Resident #H's name) arm; (Resident #H's name) became unsteady during the transfer from the wheelchair to the shower chair and she states that she held (Resident #H's name) by the hips so that she would not fall and helped her to sit in the chair. She also stated that she asked (Resident #H's name) about the bilateral scars that are located on her shoulders and (Resident #H's name) stated in return that she had broken both of her arms before. She said that she did take the clothes from (Resident #H's name) and she explained to (Resident #H's name) that the clothes were dirty that was the only reason why she was taking them, but (Resident #H's name) did not want her to and the nurse told her to just give them back if that's what she wanted. (CNA #1's name) stated that she was thinking more on the side on (sic) contaminating the clean clothes that (Resident #H's name) had just put on after her shower. (CNA #1's name) also stated that she told (Resident #H's name) that her daughter worked here as well and she never do (sic) anything to jeopardize her job or any resident. She stated that she meant nothing bad by telling (Resident #H's name) that. | | | |

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| | There was not (sic) abuse found to be true. Three other alert and oriented residents were interviewed on the same hall and none of them voiced any complaints about the care that they have received. The CNA (CNA #1's name) was informed that she would no longer take care of the (sic) (Resident #H's name). (CNA #1's name) received one on one coaching regarding how residents may perceive things. An in-service was provided to all of the staff on abuse and customer service."<br><br>The cover letter and fax verification page indicated the information had been faxed to Indiana State Department of Health on 4/18/11.<br><br>The closed record of Resident #H was reviewed on 6/7/11 at 11:15 a.m. Her diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, bipolar, and chronic obstructive pulmonary disease.<br><br>A 14 day Minimum Data Set Assessment, dated 4/21/11, indicated the resident was understood and could understand. She scored a 15 on the Brief Interview of Mental Status which indicated she was cognitively intact.<br><br>Interview with the DoN on 6/7/11 at 11:25 | | | |

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| | a.m., indicated LPN #1 was the nurse who told CNA #1 to give Resident #H her clothes back but she was not in the shower room where the incident happened.<br><br>Interview with the DoN on 6/7/11 at 12:45 p.m., indicated both ,LPN #1 and LPN #2, were aware of the allegations on the day of the incident. The DoN further indicated she was not made aware of the allegation until she returned to the facility on 4/18/11. She also verified that CNA #1 was not sent home on 4/16/11, the day the allegation was made, but was suspended pending the investigation on 4/18/11. She then indicated that LPN #1 and LPN #2 had not contacted her when the allegation was made because they did not know that was what they were to do in the event of an allegation of abuse.<br><br>Interview with the DoN on 6/7/11 at 2:30 p.m., indicated she immediately informs the Administrator when she receives an allegation of abuse.<br><br>The federal tag relates to Complaint IN00090935.<br><br>3.1-28(a) | | | |

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| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on record review and interview, the facility failed to ensure physicians' orders were followed for 1 of 6 residents reviewed with changes in medication orders in a sample of 9 related to not administering artificial tear ointment. (Resident #D)<br><br>Findings included:<br><br>The closed record for Resident #D was reviewed on 6/6/11 at 12:40 p.m. The resident's diagnoses included, but was not limited to, pneumonia, weakness, dementia ovarian cancer, and anemia.<br><br>A physician order, dated 5/14/11 at 1930 (7:30 p.m.), indicated "artificial tears ointment apply to both eyes twice daily and as needed for dry eyes.<br><br>Review of the May 2011 Medication Administration Record (MAR), indicated no entry had been made for the artificial tear ointment twice a day and as needed for dry eyes.<br><br>Interview with the Pharmacist on 6/6/11 at 2:30 p.m., indicated the pharmacy had | F0282 | F282 1. Unable to correct, as Resident #D has been discharged from the facility. 2. All residents have the potential to be affected by the alleged deficient practice. 3. All licensed staff will be re-educated by 7-1-11 regarding transcription of new orders on the Medication Administration Record and Treatment Administration Record. 4. The DON or designee will audit new orders at least 5x/week to ensure orders are transcribed accurately on the Medication Administration Record and Treatment Administration Record. The results of these findings will be reviewed in the Quality Assurance meeting monthly x3, then quarterly x2 to ensure compliance. 5. Compliance date: July 7, 2011 | 07/07/2011 |

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| | received an order on 5/14/11 after the pharmacy closed. The prescription was not sent out until 5/16/11 since the pharmacy was closed on 5/15/11.<br><br>Interview with LPN #2 on 6/6/11 at 3:15 p.m., indicated she had taken care of Resident #D. She indicated she knew there was an order for artificial tear ointment because she had written the order when the resident complained of her eyes being dry. LPN #2 opened the medication cart and the tablet medications were observed for Resident #D. There was no artificial tear ointment for Resident #D in the medication cart.<br><br>Interview with LPN #1 on 6/7/11 at 9:02 a.m., indicated when she passes medications she verifies the resident and obtains their medications by looking at the MARs to see what medications were ordered.<br><br>Interview with the Director of Nursing on 6/7/11 at 9:30 a.m., indicated she was not aware of the order for the artificial tears not being given to Resident #D and the order not being written on the MARs. She further indicated that when a new order for a medication was obtained from a physician the order should be transcribed on to the MAR. She had nothing to add as to why the order had not | | | |

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| | been transcribed to the MAR or why LPN #2 had indicated she had not given the medication to Resident #D.<br><br>This federal tag relates to complaint IN00090935.<br><br>3.1-35(g)(2) | | | |
| F0385 SS=D | A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.<br><br>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.<br>Based on record review and interview, the facility failed to ensure a resident's personal physician responded timely after multiple attempts were made to contact the physician related to a critically high sodium level for 1 of 5 residents reviewed for dehydration in the sample of 9. (Resident #D and Physician #1)<br><br>Findings included:<br><br>The closed record for Resident #D was reviewed on 6/6/11 at 12:40 p.m. She was admitted to the facility on 5/13/11. Her diagnoses included, but was not limited to, pneumonia, weakness, dementia, | F0385 | F385 1. As stated in the 2567, Resident #D was seen by the primary physician on 5/18/11 and was admitted to the hospital. 2. All residents have the potential to be affected by the alleged deficient practice. 3. All physicians have been contacted regarding assignment of alternate physician coverage, andall resident records will be updated to reflect the alternate physician assigned. Licensed staff will be re-educated by 7-1-11 regarding the policy for physician notification and alternate physician notification if the primary physician is unavailable or does not respond in a timely manner. 4. The DON or | 07/07/2011 |

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| | ovarian cancer, and anemia.<br><br>A lab test result, dated 5/17/11, indicated a sodium level of 163. The reference range was 136-147. The lab test indicated the results had been verified and critical values were called and faxed with read back to nurse (Nurse's name) at 11:06 a.m., on 5/17/11. The BUN (blood urea nitrogen) was 43 with a reference range of 8 to 28. At the bottom of the lab result indicated MD (physician) and family aware with a date of 5/18/11.<br><br>A progress note, dated 5/17/11 at 11:10 a.m., indicated a critical lab value with sodium at 163. The Physician #1 was paged and his office was called with no answer at this time. Her mucous membranes were pink. At 14:40 (2:40 p.m.), Physician #1 was called via cell phone three times since the labs results were received and there was no answer. The staff was still waiting a return call from Physician #1. She took 240 CC (Cubic centimeters) of fluid with lunch and 120 cc of water with medications during the shift.<br><br>A progress note, dated 5/18/11 at 9:00 a.m., indicated staff attempted to call Physician #1 via cell phone regarding the resident's elevated sodium level. There was no answer. Staff attempted to call | | designee will review lab results and change of condition progress notes at least 5x/week to ensure the primary physician or alternate physician were notified and responded in a timely manner. The results of these findings will be reviewed in the Quality Assurance meeting monthly x3, then quarterly x2 to ensure compliance. 5. Compliance date: July 7, 2011 | |

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| | Physician #1's office and received answering service and was instructed to try reaching the physician via cell phone. At 17:15 (5:15 p.m.) Physician #1 was notified of the critical sodium level. The physician indicated he would be in to visit the resident. At 17:30 (5:30 p.m.), Physician #1 was making rounds and a new order was received to send the resident to the hospital as a direct admit .<br><br>A doctor's progress note, dated 5/18/11, indicated the resident was weak, ENT (eyes, nose, throat) was very dry bucal (mouth). Her sodium was increase at 163 and her BUN was increased at 43. She had hypernatremia (high sodium) and needed to be admitted to the hospital.<br><br>A History and Physician from the hospital, dated 5/19/11, indicated, "84 y/o (year old) f (female), nh (nursing home) resident, I saw at the nh yesterday found to be clinically dehydrated with high NA (sodium) of 160's and was directly admitted to the hospital."<br>Physical exam: "She appears well-developed and well-nourished. She appears lethargic. She appears cachectic. She is uncooperative. She appears ill. No distress."<br>Mouth/throat: "Mucous membranes are dry."<br>Labs collected 5/18/11 at 2230 (10:30 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING 00<br>B. WING | 06/07/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNSHIRE HEALTH CARE CENTER | 8380 VIRGINIA ST<br>MERRILLVILLE, IN46410 |

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| | p.m.): BUN of 47 with a reference range of 7-17 and a sodium of 166 with a reference range of 137-145.<br>Assessment and plan: "Patient active hospital problem list. Dehydration with hypernatremia (high sodium), dehydration, hypernatremia, dementia, hypertension, atrial fibrillation, and uterine cancer by history."<br><br>The Nurse Consultant provided the Administrative Physician Notification for Change in Condition Policy on 6/6/11 at 2:40 p.m. The policy indicated, "The following symptoms, signs and laboratory values should prompt immediate notification of the physician. Immediate implies that the physician should be notified as soon as possible, either directly or by beeper/pager. If you do not obtain a response from the physician, call the designated alternate physician. If you still do not receive a response, notify the Director of Nursing for further instruction."<br>Laboratory results: Sodium under 125 or over 150.<br><br>Interview with the Director of Nursing on 6/7/11 at 9:30 a.m., indicated the Physician #1 was the Medical Director. She indicated the facility had never had a problem with contacting him until the issue with Resident #D's critical sodium | | | |

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| | level. She indicated she knew it had been over twenty-four hours before the physician was notified and she needed to speak to the Administrator to see who staff were to call if Physician #1 could not be reached. She also indicated Resident #D was only to be in the facility for a few days before she was to be discharged home. She had nothing further to offer.<br><br>Interview with the Director of Nursing on 6/7/11 at 10:15 a.m., indicated the Administrator had informed her Physician #2 was Physician #1 back up. She further indicated there had been no attempt to call Physician #2 when the critical sodium labs were received.<br><br>This federal tag relates to complaint IN00090935.<br><br>3.1-22(b)(1)<br>3.1-22(b)(2) | | | |